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defined in 42 C.F.R. chapter 413 and as modified by this Plan). However, if a Provider has historical cost data of providing Acuity Level D services under a state pilot program, the rate will be based on the lesser of the pilot program or the facility's projected costs.

VII. INFLATION AND OTHER MISCELLANEOUS PROVISIONS

A. Application of Inflation and Other Adjustments to Establish Provider-Specific Prospective Payment Rates

1. Annual cost increases shall be recognized by applying the Inflation Adjustment (Section I. Y.) to the historical costs and/or Basic PPS Rates.

2. For years in which the Department performs a Rebasing, cost increases attributable to inflation that has occurred since the Base Year shall be recognized as follows:

   a) The Basic PPS Rates shall be standardized to remove the effects of varying fiscal year ends;

   b) The Basic PPS Rates shall be multiplied by one plus the cumulative Inflation Adjustment;

   c) For the purpose of determining the Inflation Adjustment, the Department shall use the most current and accurate data that is then available;

   d) To ensure the prospective nature of the system, that data shall not be retroactively modified or adjusted.

3. For years when the Department does not perform a Rebasing, cost increases due to inflation for the upcoming rate year shall be recognized as follows:

   a) The Department shall multiply the Adjusted PPS Rate (excluding any rate reconsideration increases) in effect on June 30th of the immediately preceding fiscal year by one plus Inflation Adjustment for the following state fiscal year;

b) To ensure the prospective nature of the payment methodology, the Inflation Adjustment shall not be retroactively modified or adjusted.

B. Limitations on Long-Term Care Provider Reimbursement

1. Notwithstanding any other provisions of this Plan, aggregate payments to each group of facilities (i.e., Nursing Facilities or ICF/MRs) may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413). In addition, aggregate payments to each group of State-operated Providers (i.e., Nursing Facilities or ICF/MRs) may not exceed the amount that can reasonably be estimated would have been paid under Medicare reasonable cost principles of reimbursement. If a formal and final determination is made that payments in the aggregate exceeded the Upper Limit and federal financial participation is disallowed, then the Department may recoup any payments made to Providers in excess of the Upper Limit.

2. Notwithstanding any other provisions of this Plan, payment for out-of-state long-term care facility services shall be the lesser of the facility's charge, the other state's Medicaid rate, or the statewide weighted average Hawaii Medicaid rate applicable to services provided by comparable Hawaii Providers.

3. Notwithstanding any other provision of this Plan, no payments shall be made for the improper admission of or care for mentally ill or mentally retarded individuals, as those terms are defined in section 4211 (e)(7)(G) of OBRA 87.

C. Adjustments to Base Year Cost

1. Adjustments to a Provider's Base Year Cost Report that occur subsequent to a Rebasing that utilizes that Base Year Cost Report shall not result in any change to the component rate ceilings for the Provider's peer group.

2. Beginning with the FY 98 Rebasing, the following rules shall apply to changes to a Base Year Cost Report that are made after a Rebasing occurs:

a) If a Provider's PPS Rates are based upon a cost report that is not finally settled, then the Department shall not adjust those rates based upon subsequent changes to the Base Year Cost Report; provided, however, that the Provider may seek revisions to that Base Year Cost Report at the first available opportunity to seek a rate reconsideration.

3. The PPS rate calculation process is complex and requires an extensive commitment of the Department's resources. Occasionally, the Department may uncover or have brought to its attention minor data extraction or calculation errors that affect one or a few Providers. Unless the Department reasonably expects the correction of an error for one or a few Providers to have a significant impact on the statewide weighted averages or component ceilings, the Department need not recalculate those averages or ceilings to reflect a recalculation of the Basic PPS Rates of the one or few Providers.

D. Rebasing the Basic PPS Rates

The Department shall perform a Rebasing following the methodology but using updated cost report data as described in Section V so that a Provider shall not have its Basic PPS Rates calculated by reference to the same Base Year for more than four state fiscal years.

VIII. ADJUSTMENTS TO THE BASIC PPS RATES

A. Each proprietary Provider is eligible to receive the ROE Adjustment. The ROE adjustment shall be calculated by identifying the appropriate amounts from the Base Year Cost Report or other sources, and dividing those amounts by the Provider's Base Year patient days to obtain a Base Year ROE per diem. The Base Year ROE Adjustments shall receive the same increase to reflect inflation as all other base year costs.

B. All proprietary Providers shall receive the GET Adjustment. The GET Adjustment shall be paid by increasing the Basic PPS Rates plus all applicable adjustments by 1.04167.

C. Nursing Facilities who qualify shall receive the Capital Incentive Adjustment, the G&A Incentive Adjustment, or both. Due to the limited number of ICF/MRs, those facilities shall not be eligible to receive either the Capital Incentive or G&A Incentive Adjustments.

D. Beginning with PPS rate year July 1, 1995 to June 30, 1996, qualifying NFs shall receive the "G & A Small Facility Adjustment".

E. The Total PPS Rates

1. A Provider's Basic PPS Rate shall equal the sum of its direct nursing, G&A and capital per diem components for each Acuity Level as calculated under this Plan. A New Provider's Basic PPS Rate shall be the per diem rate calculated under the provisions of Section VI.A. The Basic PPS Rate for a Provider with New Beds shall be the per diem rate calculated under the provisions of Section VI.B.

2. A Provider's Adjusted PPS Rate shall be the product of the following formula:

Basic PPS Rate
+ Capital Incentive Adjustment [if applicable]
+ G&A Incentive Adjustment [if applicable]
+ ROE Adjustment [if applicable]
+ G&A Small Facility Adjustment [if applicable]
Subtotal

x GET Adjustment [if applicable])

= Adjusted PPS Rate

3. A Provider's Total PPS Rate shall be the Adjusted PPS Rate plus any rate increases granted pursuant to rate reconsideration requests.

4. If the Department reduces the Grandfathered Capital Component of a New Provider or a Provider with New Beds due to an inaccurate or unreasonable projection of capital costs by the Provider.

B. Requests for reconsideration shall be submitted in writing to the Department and shall set forth the reasons for the requests. Each request shall be accompanied by sufficient documentation to enable the Department to act upon the request. Documentation shall include data necessary to demonstrate that the circumstances for which reconsideration is requested meet one or more of the conditions specified in Section IX.A. The requests shall include the following:

1. A presentation of data to demonstrate the reasons for the Provider's request for rate reconsideration.

2. If the reconsideration request is based on changes in patient mix, the Provider must document the change using well established case mix measures, accompanied by a showing of cost impact.

3. A demonstration that the Provider's costs exceed the payments under this Plan.

C. Except as otherwise provided in this Plan, a request for reconsideration shall be submitted within 60 days after the annual PPS Rate is provided to the Provider by the Department, or at other times throughout the year if the Department determines that extraordinary circumstances occurred or if the circumstances defined in Section IX.A.1 occur.

D. Pending the Department's decision on a request for rate reconsideration, the Provider shall be paid the PPS Rate initially determined by the Department. If the reconsideration request is granted, the resulting new PPS Rate will be effective no earlier than the first day of the PPS rate year.

E. A Provider may appeal the Department's decision on the rate reconsideration request. The appeal shall be filed in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii

Administrative Rules. A copy of the Hawaii Administrative Rules is appended to this Plan as Exhibit 17-1736.

Except as noted below, rate increases granted pursuant to the rate reconsideration process shall not exceed an amount equal to the sum of the component ceilings for a particular Provider's classification minus the Provider's Basic PPS Rate.

1. If a Provider is either New or has added New Beds and its Basic PPS Rate is calculated under Section VI, then a rate increase shall not exceed the difference between the sum of the ceilings for the direct nursing and general and administrative components and the sum of the Provider's facility-specific components for those categories.

2. If a Provider is receiving the Grandfathered Capital Component, then the increase shall not exceed the difference between the sum of the direct nursing and G&A component ceilings and sum of the Provider's direct nursing and G&A components.

3. For Providers that qualify for the " G & A Small Facility Adjustment", the sum of the component ceilings is to reflect the increase to the G & A component ceiling as described in Section I.V.

F. Rate reconsideration granted under this Section shall be effective for the remainder of the PPS rate year. If the Provider believes its experience justifies continuation of the reconsidered rate in subsequent fiscal years, then it shall submit information to update the documentation specified in Section IX.B within 60 days after receiving notice of the Provider's rate for each subsequent PPS rate year. The Department shall review the documentation and notify the Provider of its determination as described in Section IX.D. The Department may, at its discretion, grant a rate adjustment that will be incorporated into the Provider's rate for one or more of the following PPS rate years.

G. The decision to grant a rate reconsideration request is subject to the Department's discretion. In exercising that discretion, the Department may consider that a Provider's Adjusted PPS Rate includes a Grandfathered component or Incentive Adjustment.

X. COST REPORT REQUIREMENTS

A. All Providers shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.

B. Beginning with cost reporting periods ending on or after January 1, 1996, participating Providers shall submit the following on an annual basis no later than five months after the close of each Provider's fiscal year:

1. Uniform cost report;

2. Working trial balance;

3. Provider cost report questionnaire;

4. If the Provider has its financial statement audited, then a copy of that audited financial statement;

5. Disclosure of appeal items included in the cost report;

6. Such other cost reporting and financial information as the Department shall request. This information may include segregation of certain costs of delivering services to Acuity Level C Residents as opposed to Acuity Level A Residents.

C. In subsequent years, the Department may require Providers to classify their costs according to the components defined in Section V.B.1 and interpretive guidelines provided by the Department and submit that classification with its cost report. Final classification of costs into appropriate components shall be at the discretion of the Department.

D. Claims payment for services will be suspended 100 percent until an acceptable cost report is received. A 30 day maximum extension will be granted upon written request for only when a provider's operations are significantly adversely affected due to extraordinary circumstances beyond the control of the provider, as provided in Medicare guidelines.

E. Each Provider shall keep financial and statistical records of the cost reporting year for at least six years after submitting the cost report form to the Department and shall make such records available upon request to authorized state or federal representatives.

XI. AUDIT REQUIREMENTS

A. The Department or its fiscal agent shall conduct periodically either on-site or desk audits of cost reports, including financial and statistical records of a sample of participating Providers in each Provider classification.

B. Reports of the on-site or desk audit findings shall be retained by the Department or its fiscal agent for a period of not less than three years following the date of submission of the report.

C. Each Provider shall have the right to appeal audit findings in accordance with the procedural requirements of Chapter 17-1736 of the Hawaii Administrative Rules.

XII. PUBLIC PROCESS

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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IX. ADMINISTRATIVE REVIEW - RATE RECONSIDERATION

A. Providers shall have the right to request a rate reconsideration for the following conditions:

1. A change in ownership, leaseholder, or operator, without a change in licensure and certification, which shall be grounds for rate reconsideration only to the extent authorized in Section II.C.6.

2. Extraordinary circumstances including, but not limited to, the following: acts of God; changes in life and safety code requirements; changes in licensure law, rules, or regulations; significant changes in patient mix or nature of service occurring subsequent to the Base Year; errors by the Department in data extraction or calculation of the per diem rates; subject to Section VII.C, inaccuracies or errors in the Base Year Cost Report; or additional capital costs resulting from renovation of a facility that does not result in additional beds but otherwise are attributable to extraordinary circumstances. Mere inflation of costs, absent extraordinary circumstances, shall not be a basis for rate reconsideration.

3. To determine in advance the amount of rate reconsideration relief, if any, that will be granted to the Provider for an anticipated future cost in excess of $50,000, or $1,000 per bed, whichever is less. The Provider must be otherwise ready to incur the cost, and it must be attributable to a proposed capital expenditure, change in service or licensure or extraordinary circumstance. Any determination by the Department is subject to the Provider actually incurring the anticipated cost. If the actual cost is greater or lesser than the anticipated future cost submitted by the Provider, then the Department may adjust its rate reconsideration relief determination either on its own initiative or by supplemental request of the Provider. A Provider that fails to request an advance rate reconsideration from the Department assumes the risk that no rate reconsideration relief may ultimately be available.